July 3, 2003

TO: **Healthy San Diego Health Plans**
FROM: **Evalyn Greb, Chief, LTCIP**
Mark Meiners, LTCIP Consultant Team Leader

PRELIMINARY CONSULTANT TEAM STRATEGY PROPOSAL

Below you will find a brief outline summarizing the proposed strategy for implementing LTCI with the HSD model. More detail on key aspects of the operating model and actuarial estimates are provided in the attachments for your consideration and input. You should consider this work a first draft for the purpose of stimulating your feedback and input.

Please join with us and the other members of the consultant team (Charles Birmingham, Karen Kalk, and David Ogden) to further discuss these materials on July 17 at 1 PM at AIS in the training room. In the mean time, however, call us at 858-495-5428 for any clarification that may help you prepare for this meeting. We would like to suggest that you consider bringing your operating and fiscal officers as that might help further our progress toward implementation. Thank you for your time and energy on this project.

PROPOSAL
Long Range: provide 95,000 ABDs with two options (Physician Strategy and HSD+) for improved care; those who don't choose will be enrolled in HSD+:

1. **Physician Strategy** (under development)
    - Development of adequate incentives to engage MDs
    - Facilitation / implementation of chronic care across health and social services
    - Coordination of benefits across Medicare & Medi-Cal for "duals".

2. **Healthy San Diego Plus (HSD+)** to be phased in according to the following order:
    - Dually eligible HSD nursing facility (NF) residents who are aged
    - Dually eligible HSD NF "certifiable" (NFC) residing in community who are aged
    - Dually eligible non-HSD at NF/NFC level who are aged
    - All other HSD ABDs
    - All other ABDs

HSD+ Funding:
- **Medi-Cal cap rate for acute, long term care, IHSS, 1915(c) waiver**
- **Medicare cap rate for persons dually eligible**

Why? This order allows plans to:
- Receive Medicare and Medi-Cal capitated rate from the beginning
- Begin with highest resources/client
- Build infrastructure for highest utilizers
- Build care management competence

How? Waivers:
- Amend current Medi-Cal 1915(b) for mandatory enrollment into either option
- Apply for 1915(c) to supplement regular Medi-Cal for NFC who can be maintained at home at budget neutral level
- Apply for Medicare 402 waiver to allow HSD health plans to receive Medicare that will compliment the Medi-Cal capitated rate
- Build maximum flexibility into waivers at care management level

Who? HSD plans who:

- qualify for HSD+ and choose to participate
- are with or without current Medicare participation
- may subcontract for LTC

How LTCIP staff can help health plans:

- Defining "blended" (Medi-Medi) funding, benefits, and criteria
- LTC Network development assistance
- Special populations planning assistance: rural, isolated, minorities
- Link with Public Authority for personal care assistance
- Link with community resources, including caregiver resources
- Chronic Care Management standards and training
- Development of standard risk screening, assessment, care management tools
- Quality Assurance standards for LTC Network
- Training on best practices in chronic care management across professions
- Network of Care training and support
- Streamlined, useful data collection criteria
- Applying for private funding for local HSD+ infrastructure building
- (other ideas?)

How HSD health plans can help get to HSD+:

- **Your response to this proposal**
- **Your participation in a meeting w/consultant team July 17, 1-3 PM at AIS**
- Assistance with design of Administrative Action Plan and waiver applications
- Assistance in defining "medical or social need" as basis for benefits
- Ideas about state contract language
- List of LTC educational needs from LTCIP staff/resources
- Assistance in developing protocol for screening/enrolling high risk individuals
- Quality Assurance integration with HSD and other collaboration ideas

Actuarial Consultant is:

- Reviewing San Diego County Medi-Cal and Medicare Cost Experience
- Will project potential cost experience under managed care and compare to Medicare payment rates
- Will project alternate long term care costs
- Says there appears to be reasonable opportunities for motivated health plans (see attached preliminary actuarial report)

<u>HEALTH PLAN RESPONSE</u>

- **What's missing**
- **Your concerns, issues, needs**
- **Recommendations back to consultant team on July 17 or**
- **Schedule teleconference w/consultant team at July 17 meeting**

ATTACHMENT A

San Diego LTCIP Operating Model
(Prepared by Charles Birmingham and Karen Kalk, with input from the other consulting team members, based on a review and synthesis of the San Diego LTCIP stakeholders input and existing Medicare/Medicaid Integration Program strategies.)

I. Background

A. This operating model will define an approach to long term care integration that San Diego's stakeholders can build around the health plans that currently participate in the Healthy San Diego (HSD) program, while offering choice and improved care to all aged and disabled San Diegans.
   - The long-range plan would be to create a "scaleable" operating model that would serve all of the approximately 95,000 Medi-Cal ABD's in the County.
   - The State would contract with interested HSD health plan to accommodate the broader scope of services required for ABDs, and the County HSD staff would be expanded for the larger program.

B. The operating model will rest on sound actuarial assumptions and integrate into one pool all sources of reimbursement for the full range of medical, psychosocial and supportive services required to meet the needs of ABD enrollees. A preliminary actuarial analysis is provided as Attachment B. Funding streams include:
   - Medi-Cal acute care;
   - Risk-adjusted Medicare acute care;
   - Medi-Cal long term care; and
   - All related sources of programmatic money such IHSS and a Home and Community-Based (HCBS) service waiver.

II. The Long Range Plan

A. It is proposed that the governance and administrative structure of HSD be expanded to give an ABD consumer the opportunity to choose between two service models designed to improve the coordination of their care:
   - Model #1, Physician Strategy (Managed Fee-for-Service), currently under development, would allow its members to choose a physician from a list of providers who agree to the State's contractual requirements that would include some level of care coordination activity. Reimbursement of services would be on a fee for service basis either from Medicaid or Medicare or some combination depending upon the member's circumstances.
   - Model #2, the *Healthy San Diego Plus* (HSD+) model of Long Term Care Integration, described in this proposal, will provide a comprehensive approach to coordination of all acute, psychosocial and long term care services to be reimbursed by a combination of capitated Medi-Cal and Medicare rates paid to HSD health plans.

B. HSD+ would be authorized through new contractual arrangements with interested HSD health plans to reflect the new scope of services for ABDs and the negotiation of new rates with the State (Medi-Cal) and CMS (Medicare).

III. Who Will Be Covered

A. The HSD+ model would cover Medi-Cal only and Dually Eligible ABDs.
   - Key target populations for enrollment are NF-certifiable members currently enrolled in HSD health plans, including NF residents, NF-certifiable persons not enrolled in HSD, including NF residents, other ABD cohorts in the 9,000 ABD members of HSD health plans and then the balance of ABDs outside of HSD. A phase-in strategy needs to be discussed with HSD health plans.

IV. What Waivers Will Be Required

A. Working in concert with the State, HSD+ will apply for a 402/222 Demonstration waiver. The 402 Waiver is important because it will allow for changes in current Medicare reimbursement practices.
   - Under the 402 waiver in Minnesota, the state holds the contract with health plans for both Medicaid and Medicare services. The state pays the Medicaid rate, while CMS pays the Medicare cap directly to the health plans, allowing the payment to be blended at the plan level.
   - The 402 waiver should ensure that non-M+C plans are able to participate in the demonstration project and that these plans will not be required to be open for enrollment as an M+C plan. In the Wisconsin Partnership, CMS issued operating protocols with the 402 waiver that allowed health plans to enroll Medicare eligibles in lieu of having an M+C license.
   - The design of a 402 Medicare waiver would be aligned with the current activity at CMS to develop risk-adjusted Medicare rates through coordinated care and disease management demonstration projects for the dually eligible. Recently approved or proposed CMS Demo rates suggest that Medicare reimbursement for certain disease-related cohorts in the ABD population could reach $2,500-$3,000 pmpm. HSD+ would seek to further enhance risk-adjusted rates with the frailty adjuster that is under development at CMS.

B. A 1915 (b) waiver would be required to develop a local managed care initiative that is not statewide and to create the lock-in to a two-model system. The state's existing 1915 (b) waiver could be used but with an amendment to mandate aged, blind, and disabled enrollment to accommodate this new initiative.

C. A new and larger 1915(c) waiver will be required to enable wraparound services to be provided to prevent higher levels of utilization for those who are enrolled and are NF"certifiable" but living in the community.

V. Key Program Components

A. The comprehensive system of care coordination envisioned in this model would be built by the health plans and HSD+ staff around the following elements:
   - A common entry point into the HSD+ system in the form intake, risk screens, and needs assessment instruments that could be helpful to and used by all health plans. This would provide a basis for uniform evaluation of needs and a common care management vocabulary for external QA.
   - Care plans development, in conjunction with assessment information, can be based on an electronic set of algorithms that both have drop-down assessment triggers, as well as cost effectiveness indicators built into the system.
   - Care coordination standards and protocol to be included in the contract language that is administratively and operationally designed to meet HSD+ consumer-centered goals. This system would tie the social model and medical models together and be based on an interdisciplinary team approach.
   - Common data requirements will be included in contract language and should be designed to be useful as a risk management tool, incorporating claims and encounter data that HSD+, the State and CMS will require from health plans for retrospective QA and measurement of the financial solvency of HSD+. In addition, a data warehouse could be developed to integrate data from various relevant sources, possibly along the lines of the PACE Protocol. Relevant data sources include the MDS for nursing home care, OASIS for home health care, HEDIS (the Health of Seiors/SF-36 measures) and the CAHPS (Consumer Assessment of Health Plan Data) for Medicare data. Also, there are sophisticated applications for point of service data capture using PDA's that should be explored to facilitate the integration of data starting at the point of service.
   - A new and expanded network of provider services that includes the full list of home and community-based care, as well as professionals specializing in chronic care of aging and disabled persons.

- The potential use of technology to facilitate remote monitoring of community-based and/or homebound patients could be explored: strategic partnerships with specialized vendors, among them Alere, Inc., that does remote monitoring of CHF patients; Eliza Corporation that uses sophisticated speech and pattern recognition technology for automated telephone screening of at-risk patients; and EverCare that does home-based and nursing facility-based medical management of frail seniors.

VI. The Financial Model

A. A reimbursement and savings model will incorporate all probable sources of new reimbursement and make experience-based savings projections. In turn, this will provide a pool of funds that would be employed to improve chronic care and to shift long term care from institutional settings to innovative, community-based acute care and wraparound services.

B. A preliminary actuarial analysis has been prepared (see Attachment B). This model suggests that:
   - Aged, dually eligible ABDs may under certain circumstances generate a substantial additional margin beyond the health plan's normal administrative retention to reinvest in the enhanced care management and innovative services envisioned by HSD+.
   - Disabled, dually eligible ABD's may be problematic and, under current assumptions, would not generate such a margin.
   - The outlook for both segments may improve under the new 61-condtion risk adjustment model to be phased in beginning in 2004, and it may be advisable to consider disease management or coordinated care demonstrations for certain ABD cohorts to enhance Medicare reimbursement.

C. HSD+ is committed to helping health plans reach a critical mass of membership to mitigate outlier risk, and health plans interviewed have indicated 2,500 members would be viewed as sufficient. Auto assignment of ABD's who do not make a choice between HSD+ model and the Physician Strategy model to HSD+ would facilitate building enrollment to critical mass.

D. The State Office of Long Term Care has indicated that it would not consider disenrollment for long-term nursing facility residents, but would consider risk sharing after a certain dollar level has been reached (a risk corridor approach) and catastrophic reinsurance of very high cost cases. In addition, the State is open to risk-sharing agreements with health plan participants in the early stages of the program as membership grows to a desired critical mass.

E. The question of whether rates will be negotiated with the California Medical Assistance Commission (CMAC) should be resolved. In Section 14089.05 of the Welfare and Institutions Code of the State of California, there is a reference to a possible exception to rate negotiations with CMAC for "special projects, " approved by the Department of Health. The State Office of Long Term Care could play a highly instrumental role in helping San Diego gain this exception or, worst case, in facilitating negotiations with CMAC toward the launch of a financially stable pilot.

VII. The Interim Plan: Building Infrastructure

A. An Administrative Action Plan will be developed for a planning and waiver development process that could take as much as two years. A reasonable implementation date might be July 1, 2005.

B. The principle coordinating mechanism between providers and HSD should remain the Consumer and Professional Advisory Committee and its subcommittees.

C. The Administrative Action Plan should place special emphasis on technical assistance for health plans and home and community-based care providers. The experience in Wisconsin's program also offers a strategy for technical assistance. There, the local authority and providers developed the Long Term Care

Partnership, Inc., a non-profit corporation that attracted financial support for the development and provision of technical assistance to health plans that were for the first time managing blended capitation for acute and long term care services for an ABD population. Grants to this organization funded an investment that each health plan would otherwise have had to make on its own, underwrote the hiring of technical experts who facilitated timely implementation of the program, and supported "R&D" for the creation of system templates, e.g., case management standards.

D. Whether it is through this type of entity or through the HSD committee structure, the interim plan should address the following objectives:
   - Creation of a waiver development team that includes representation from health plans and stakeholders.
   - Groundwork to put into place a technical assistance program.
   - Creation of a collaborative process with health plans and providers to develop common systems and tools – risk and assessment tools, care plans and the network of wraparound services. In particular, standards and processes should be developed for credentialing of non-medical, community-based providers to mitigate the risk that health plans may otherwise incur when using community agencies that do not fall into service categories currently credentialed.
   - Exploration of new care management techniques that make population-based case management scaleable, e.g., the use of home monitoring technology for at-risk patients, as well as liaison with specialized disease management companies.
   - Development of a marketing plan that would enumerate the benefits and financial incentives associated with choosing HSD+ – for both beneficiaries and providers.

E. The HSD+ and Physician Strategy models should move forward in tandem to ensure that the desired choice of alternatives is available when the time comes to launch HSD+.

Attachment B

San Diego Long Term Care Integration
Preliminary Feasibility Analysis

July 1, 2003

Prepared by:

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Consulting Actuary

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Associate Actuary

San Diego Long Term Care Integration
Preliminary Feasibility Analysis

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I. EXECUTIVE SUMMARY

Milliman USA has been retained by the County of San Diego to assist them with an analysis of the Medi-Cal eligible population in the county and their acute and long term health care needs. The consultant team that is assisting the County recommends a two model approach (described more fully in the overall proposal) for the integration. One of the two models is called Healthy San Diego Plus (HSD+), which envisions capitating health plans for Medicare and Medi-Cal services. This report analyzes the current (2000) fee for service experience of the Medi-Cal Aged and Disabled eligibles in San Diego County and projects potential costs savings under a managed care model.

Two scenarios of managed care savings reductions are developed. Scenario A shows about 16% of Medicare + Choice (M+C) payment rates available for administration, profit and additional services for the entire dual eligible population, while Scenario B shows 22%. However, the margin is much higher for nursing home residents than for community residents. The Scenario A amount should be enough to successfully manage the Medicare acute costs while Scenario B should provide some allowance for additional services, such as community long term care services provided by Medi-Cal for only a portion of the population. The management characteristics of each scenario are summarized below:

- Scenario A – Initial, moderately managed utilization that is more likely to be achieved in the initial period of HSD+.

- Scenario B – More developed, more aggressively managed utilization, which is more likely to be achieved after HSD+ plans have gained some expertise with the target population, though a number of health plans have achieved these levels early in their experience.

The days per 1,000 in Scenario B appear that they still could be reduced by 20% or more with appropriate management. We did not do so since that would result in utilization reductions of over 50%.

We believe that Medi-Cal capitations for long term care (LTC) services for a nursing home certifiable population may be $2,050 to $2,450 PMPM for the Aged and $2,860 to $3,400 PMPM for the Disabled (80% to 90% of the LTC fee for service PMPM for nursing home (NH) residents). The cost of LTC services for community residents in the MSSP and IHSS programs is 20% to 50% of this value, allowing substantial opportunity to cover frail individuals at risk of nursing home admissions and still achieve financial breakeven. The population covered for long term care services will need to be those at high risk of nursing home admission. If 20% to 50% of those admissions can be deferred, then financial breakeven can be achieved.

The remainder of this report discusses this information in more detail. Section II discusses Medicare cost projections, Section III Medi-Cal cost projections, and Section IV potential rate cells.

This material assumes that the reader is familiar with California Medi-Cal programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the County of San Diego in setting rates for capitated long term care programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Limitations

Our analysis has been based on data provided by the University of Southern California Long Term Care Integration Center (USC). We have not audited the data but accepted it as presented. If the underlying data were to change, then our conclusions would change.

Our analysis is intended to assist the County of San Diego to determine the potential feasibility of long term care integration for Medi-Cal eligibles and may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. Other parties may wish to consult with experts trained in actuarial and financial analysis when reviewing this report. Thus, the report should only be reviewed in its entirety. This report assumes that the reader is familiar with California Medi-Cal programs – their eligibility, covered services, administration and other factors; rate setting issues and general statistical methods.

II. MEDICARE COST ANALYSIS

Tables 1-3 compare projected 2004 (M+C) payment rates for the San Diego dual eligible population to projected 2004 Medicare managed care costs. Tables 1 – 3 show the result for All Dual Eligibles, Nursing Home Residents, and Community Residents, respectively. Two scenarios of managed care savings are shown for each population, at two levels of management:

- Scenario A – Initial, moderately managed utilization that is more likely to be achieved by the initial period of HSD+.

- Scenario B – More developed, more aggressively managed utilization, which is more likely to be achieved after HSD+ plans have gained some expertise with the target population, though a number of health plans have achieved these levels early in their experience.

Chart II-A shows the projected amount available for administration, profit and additional services:

Chart II-A
San Diego County
Projected Amount for Administration, Profit, Additional Services
Medicare Benefits

	Scenario A	Scenario B
Composite Population	16.1%	22.2%
Nursing Home Residents	37.7	41.5
Community Residents	13.6	19.9

As can be seen, the proportion is much higher for NH residents.

The Scenario A amount should be enough to successfully manage the Medicare acute costs while Scenario B should provide some allowance for additional services, such as community long term care services provided by Medi-Cal for only a portion of the population. Scenarios A and B are discussed more fully below.

Each of the tables shows results separately for Aged and Disabled populations. The Aged population includes those over age 65 who were previously disabled. Note that the Disabled M+C payment rate is less than the projected managed care cost for all Disabled subpopulations while the Aged population produces substantial margins.

Tables 1-3 show projected 2000 managed care costs, trends used to project to 2004, the resulting 2004 projected costs, and projected M+C payment rates.

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M+C Payment Rate

The payment rate is based on 2000 San Diego County dual eligible age/gender data provided by CMS as support for M+C payment rates. The demographics of the entire institutional population (nursing home residents) were used for dual eligible institutional eligibles since only the total is shown by CMS. CMS data was used since USC did not have the demographics in this level of detail immediately available in light of the time available. USC can provide the same information from the data they have available given a longer time frame.

A demographic only calculation was made, as diagnostic information by individual is not immediately available from the USC database but would require resummarizing the data, which could not be done in the time available. We are pursuing obtaining this data to calculate the diagnosis based rates. The use of diagnostic risk adjustment data could raise or lower the payment rate since the Medicaid and Institutional demographic factors implicitly include some risk adjustment.

Medicare Cost Assumptions

San Diego County 2000 incurred Medicare fee-for-service payments PMPM were provided by USC, which had received them from CMS. This data combines those eligible for Parts A and B of Medicare as well as those eligible for Part B only. The data is presently separated between those eligible for Parts A and B and those eligible for Part B only in aggregate for all dual eligibles combined, not separated into any of the subpopulations shown: e.g., Aged versus Disabled, in addition to nursing home resident versus community. We applied the same adjustment to each subpopulation based on the ratio of the cost PMPM of those with both Parts A and B to all dual eligibles, since the data is not available by population.

Scenario A estimates cost under a moderately managed delivery system, which refers to a system approximately one half way between a well managed system and the present (year 2000) loosely managed system.

- Loosely managed refers to a setting with little or no attempt to manage levels of care, costs, or outcomes. It is referred to as 0% degree of health care management.

- Well managed refers to a setting with the best-observed practices in all areas of care. The individual observed practices come from many different delivery systems. No individual delivery system is achieving all of them. Well-managed targets should be viewed as benchmarks to define potential areas of improvement, rather than targets likely to be achieved in the near future. It is referred to as 100% degree of health care management.

- Characteristics of a well managed delivery system include (but are not limited to):

  - Active use of treatment guidelines, such as the Milliman *Care Guidelines*^{TM}

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- Programs to educate physicians on ways to provide care more efficiently
- Financial incentives which reward providers for efficient utilization
- On-site utilization management of inpatient services
- The use of a primary care manager
- Telephonic nurse triage
- Active use of physician assistants, nurse practitioners, and other physician extenders
- Demand management programs that teach members when to seek medical assistance
- The use of information systems that support utilization monitoring efforts and provider incentive programs
- Initial assessment of enrollees to identify high risk individuals
- Active use of case managers to identify and facilitate treatment of acute and chronically ill patients, in areas such as:
  - » Home nutrition
  - » Congestive heart failure
  - » Diabetes
  - » Asthma and other respiratory conditions

Well managed care is referred to as 100% degree of health care management. The well managed targets are based on extrapolation from well managed targets for Medicare only eligibles. However, there is much less data and direct experience with dual eligible populations. Thus, there is more uncertainty regarding the potential for savings in a dual eligible population than in a Medicare only population. This uncertainty is especially true for the Nursing Home Certifiable and Nursing Home levels of care, although PACE program experience is available.

In general, inpatient hospital care often holds the most opportunity for change and real impact on the expected costs for a Medicare population. The table below shows the moderately managed inpatient days targets in 2004:

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Moderately Managed Inpatient Days per 1,000 Targets In 2004				
	Aged		Disabled	
	Scenario A	Scenario B	Scenario A	Scenario B
Nursing Home Resident	2,350	1,808	4,616	3,551
Community Resident	1,979	1,522	4,419	3,399

The days per 1,000 in Scenario B appear that they still could be reduced by 20% or more with appropriate management. We did not do so since that would result in utilization reductions of over 50%. Each of the two scenarios could be reduced by 20% given the utilization rates shown.

Recent inpatient utilization experience from similar programs is shown below:

Dual Eligible Managed Care Programs Inpatient Days per 1,000	
PACE	1,500 to 2,000 days
Minnesota Senior Health Options (MSHO)*	1,800 days
**Mix of community and nursing home residents*	

PACE data is an average of multiple sites, while MSHO is primarily in the Minneapolis/ St. Paul area.

The Milliman USA *HMO Intercompany Rate Survey* indicates average M+C inpatient utilization of 1,195 days per 1,000 in the Pacific region. A well managed Medicare only plan could expect 700 days per 1,000; however, this rate should be viewed as a target for future time periods as this product becomes more mature. This population is most similar to a Community non nursing home certifiable population, though a non-dual population may be younger and less frail.

Moderately managed (Scenario A) in this report refers to inpatient costs approximately 70% of the way from loosely managed to well managed and non inpatient costs approximately 30% of the way from loosely managed to well managed. Historically most HMOs have managed inpatient care more successfully than outpatient care

Tables 4A-B, 5A-B, and 6A-B show the actual 2000 fee-for-service cost PMPM, the managed care savings assumptions, and projected 2000 managed care costs for all Dual Eligibles, Nursing Home Residents, and Community Residents, respectively. Table A shows Scenario A and Table B shows Scenario B. The Managed Care Savings factors shown are multiplied by the 2000 fee-for-service cost PMPM to project 2000 managed care costs. The hospital inpatient cost per day is projected to increase as the inpatient utilization declines.

The 2000 payment data was trended to 2004 using Medicare fee-for-service trends as reported by CMS. This assumption assumes that Medicare reimbursement levels are used by HSD+, adjusted for the higher intensity of service that is expected to occur when utilization is reduced from fee-for-service levels.

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III. MEDI-CAL COST ASSUMPTIONS

We have also analyzed the Medi-Cal cost PMPM payments for single and dual eligibles. We do not know what the corresponding payment from the State of California will be.

The HSD payment rates are confidential and the State pays Aged and Disabled/Blind capitation rates that are a blend of Medicare and non-Medicare eligibles. Thus, it is difficult to develop a representative capitation rate to compare to the managed cost estimates.

The Medi-Cal managed care reductions are smaller than those assumed for Medicare costs.

- For dual eligibles, they represent payments for Medicare deductibles and coinsurance. These amounts will still generally need to be paid under a managed scenario, especially if providers expect Medicare reimbursement in total, versus the blended Medicare/Medi-Cal reimbursement that occurs under fee for service for dual eligibles.

- For single eligibles, the underlying utilization is less than that for the dual eligibles so smaller reductions are possible.

Tables 7-11 show 2000 Medi-Cal fee-for-service costs, managed care savings factors and projected managed care costs for All Eligibles, NH residents, non NH residents, MSSP users and IHSS users, respectively. In Home Supportive Services Program (IHSS) and Multi-purpose Senior Services Program (MSSP) are state programs administered through the County of San Diego to help maintain frail individuals in the community. The users of these services overlap with NH and non NH residents so we are unable to completely separate the populations.

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Medi-Cal Long Term Care Services

We have compared Medi-Cal long term care (LTC) costs for NH residents and community residents. We used IHSS and MSSP users as proxies for community LTC even though only MSSP users are NH certifiable – since IHSS has a much higher number of users than MSSP. We used the following as LTC service proxies:

- SNF / NH
- Home Health
- IHSS
- MSSP

Chart III-A below compares the 2000 Medi-Cal cost PMPM for these services between the NH residents and community LTC residents (IHSS / MSSP).

Chart III-A
San Diego County
Long Term Care Services
Community Plus Institutional for Dual Eligibles
2000 Medi-Cal Cost PMPM

	Aged	Disabled	Disabled 65+
NH Residents	$2,566	$3,573	$3,298
MSSP	1,092	N/A	1,060
IHSS	475	574	472

Chart III-B below shows the ratio of the NH resident cost to each of the community categories.

Chart III-B
San Diego County
Long Term Care Services
Community Plus Institutional
Ratio of NH Resident Cost to Community Residence

	Aged	Disabled	Disabled 65+
MSSP	2.35	--	3.11
IHSS	5.40	6.22	6.99

The NH to MSSP ratio of 2.35 for Aged means that it takes 2.35 year (28 months) of LTC payments for MSSP users to equal 12 months of LTC payments for nursing home residents. Thus an individual could

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be enrolled in the MSSP program 1.35 years (16 months) prior to expected NH admission and spend the same amount of money on LTC services if NH admission is delayed 12 months. Any greater delay results in a savings. The IHSS ratio of 5.40 for Aged means IHSS services could be begun 4.40 years (54 months) prior to expected nursing home admission as long as nursing home admission was delayed one year and still breakeven financially.

This approach causes financial breakeven over a multi-year period. In most instances, State Medicaid programs require financial breakeven or better every contract period.

Based on the above information, the portion of a Medi-Cal capitation rate for LTC services only for a nursing home certifiable population might be:

- Aged: $2,050 to $2,450 PMPM
- Disabled: $2,860 to $3,400 PMPM

These values are 80% to 95% of the LTC PMPM for NH residents. This capitation rate might be paid for eligibles at high risk of nursing home admission. A lower capitation rate could be paid for a broader, less frail population. In the long run, we believe it is most appropriate for the LTC capitation to be based on the functional needs of the population, rather than an arbitrary measure of being at risk of nursing home admission, but such data is not presently available.

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IV. POTENTIAL RATE CELLS

We believe that HSD Plus plans should be fully at risk for acute care services as other plans would be for the M+C and Medi-Cal managed care programs. Serious consideration should be given to qualifying for the CMS frailty adjuster in light of the population targeted.

Medi-Cal capitation rates should be developed separately for Medicare and non-Medicare eligibles. We understand the system used to pay the capitations cannot achieve this separation but the underlying capitations should be calculated at this level, and periodic settlements made to adjust the Medi-Cal capitation rate paid based on the actual mix of enrollees.

There should be some limitations on the health plan risk for nursing home risk in the beginning of the program. We understand the State will not accept an absolute limit, but would accept risk sharing. An arrangement similar to that shown below could be done:

San Diego County
Potential Nursing Home Risk Structure

Days of Stay	Health Plan Risk	State Risk
0 – 180 days	100%	0%
181 – 365 days	50	50
>366 days	0	100

This arrangement is intended to be illustrative rather than specific. It can be refined based on the expectations of all parties.

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Table 1A
San Diego County Long Term Care Integration
Summary of San Diego Experience - Composite Population (Adjusted for Part B Exposure) - Scenario A

	Projected 2000 Managed Care Costs			CMS Trends from 2000 to 2004			Trended 2004 Costs		
	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged and Disabled 65+ Dual	Disabled Dual	Composite Dual
2000									
Medicare Exposure Months	338,296	161,398	97,756				436,052	161,398	597,450
Inpatient Hospital PMPM	$ 199.42	$ 369.54	$ 295.18	26.5%	24.4%	26.5%	$ 279.39	$ 459.87	$ 328.15
Inpatient Hospital Days	1,832	4,424	2,605	0.0%	0.0%	0.0%	2,005	4,424	2,534
Inpatient Hospital $/Day	$ 1,306	$ 1,002	$ 1,360	26.5%	24.4%	26.5%	$ 1,667	$ 1,247	$ 1,553.93
Skilled Nursing Facility	$ 51.14	$ 22.76	$ 49.50	23.7%	22.1%	23.7%	$ 62.82	$ 27.79	$ 53.36
Developmentally Disabled ICF	-	-	-				-	-	-
Home Health Care	20.61	18.65	35.12	27.1%	11.7%	27.1%	30.33	20.83	27.76
Outpatient Facility	23.48	36.28	32.37	58.0%	68.3%	58.0%	40.26	61.05	45.87
Laboratory	17.70	48.65	33.61	21.4%	21.6%	21.4%	25.82	59.17	34.83
Physician	88.35	161.70	124.22	21.4%	21.6%	21.4%	117.03	196.66	138.54
Other Practitioner	5.41	8.64	9.07	21.4%	21.6%	21.4%	7.56	10.51	8.36
OP Mental Health Practitioner	0.20	17.75	0.58	21.4%	21.6%	21.4%	0.35	21.59	6.08
Ambulance	8.09	10.89	10.86	58.0%	68.3%	58.0%	13.77	18.32	15.00
DME	19.28	28.85	29.44	40.7%	50.0%	40.7%	30.32	43.27	33.82
Other	42.60	54.14	35.71	21.4%	21.6%	21.4%	49.85	65.84	54.17
Total	$ 476.28	$ 777.85	$ 655.66				$ 657.50	$ 984.90	$ 745.94
Expected 2004 CMS Revenue PMPM							$ 912.96	$ 824.82	889.15
Expected Net Revenue PMPM							$ 255.46	$ (160.08)	$ 143.20

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Table 1B
San Diego County Long Term Care Integration
Summary of San Diego Experience - Composite Population (Adjusted for Part B Exposure) - Scenario B

	Projected 2000 Managed Care Costs			CMS Trends from 2000 to 2004			Trended 2004 Costs		
	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged and Disabled 65+ Dual	Disabled Dual	Composite Dual
2000									
Medicare Exposure Months	338,296	161,398	97,756				436,052	161,398	597,450
Inpatient Hospital PMPM	$ 166.74	$ 308.98	$ 246.81	26.5%	24.4%	26.5%	$ 233.61	$ 384.50	$ 274.37
Inpatient Hospital Days	1,409	3,403	2,004	0.0%	0.0%	0.0%	1,542	3,403	1,949
Inpatient Hospital $/Day	$ 1,420	$ 1,090	$ 1,478	26.5%	24.4%	26.5%	$ 1,813	$ 1,356	$ 1,689.22
Skilled Nursing Facility	$ 51.14	$ 22.76	$ 49.50	23.7%	22.1%	23.7%	$ 62.82	$ 27.79	$ 53.36
Developmentally Disabled ICF	-	-	-				-	-	-
Home Health Care	20.61	18.65	35.12	27.1%	11.7%	27.1%	30.33	20.83	27.76
Outpatient Facility	23.48	36.28	32.37	58.0%	68.3%	58.0%	40.26	61.05	45.87
Laboratory	17.70	48.65	33.61	21.4%	21.6%	21.4%	25.82	59.17	34.83
Physician	88.35	161.70	124.22	21.4%	21.6%	21.4%	117.03	196.66	138.54
Other Practitioner	5.41	8.64	9.07	21.4%	21.6%	21.4%	7.56	10.51	8.36
OP Mental Health Practitioner	0.20	17.75	0.58	21.4%	21.6%	21.4%	0.35	21.59	6.08
Ambulance	8.09	10.89	10.86	58.0%	68.3%	58.0%	13.77	18.32	15.00
DME	19.28	28.85	29.44	40.7%	50.0%	40.7%	30.32	43.27	33.82
Other	42.60	54.14	35.71	21.4%	21.6%	21.4%	49.85	65.84	54.17
Total	$ 443.60	$ 717.29	$ 607.29				$ 611.71	$ 909.54	$ 692.17
Expected 2004 CMS Revenue PMPM							$ 912.96	$ 824.82	889.15
Expected Net Revenue PMPM							$ 301.25	$ (84.72)	$ 196.98

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Table 2A
San Diego County Long Term Care Integration
Summary of San Diego Experience - Nursing Home Residents (Adjusted for Part B Exposure) - Scenario A

	Projected 2000 Managed Care Costs			CMS Trends from 2000 to 2004			Trended 2004 Costs		
	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged and Disabled 65+ Dual	Disabled Dual	Composite Dual
2000									
Medicare Exposure Months	37,857	3,818	2,697				40,554	3,818	44,372
Inpatient Hospital PMPM	$ 207.06	$ 367.04	$ 336.13	26.5%	24.4%	26.5%	$ 272.76	$ 456.76	$ 288.59
Inpatient Hospital Days	2,257	4,616	3,660	0.0%	0.0%	0.0%	2,350	4,616	2,519
Inpatient Hospital $/Day	$ 1,101	$ 954	$ 1,102	26.5%	24.4%	26.5%	$ 1,393	$ 1,187	$ 1,374.93
Skilled Nursing Facility	$ 100.47	$ 111.66	$ 146.93	23.7%	22.1%	23.7%	$ 128.14	$ 136.33	$ 128.84
Developmentally Disabled ICF	-	-	-				-	-	-
Home Health Care	1.06	2.02	5.66	27.1%	11.7%	27.1%	1.74	2.26	1.78
Outpatient Facility	36.32	47.43	64.83	58.0%	68.3%	58.0%	60.40	79.81	62.07
Laboratory	11.48	53.40	42.27	21.4%	21.6%	21.4%	16.42	64.94	20.60
Physician	79.72	167.39	151.92	21.4%	21.6%	21.4%	102.62	203.58	111.30
Other Practitioner	12.25	30.34	29.18	21.4%	21.6%	21.4%	16.24	36.90	18.02
OP Mental Health Practitioner	0.01	0.06	0.04	21.4%	21.6%	21.4%	0.01	0.07	0.02
Ambulance	18.49	40.55	38.06	58.0%	68.3%	58.0%	31.28	68.23	34.46
DME	33.40	57.25	55.13	40.7%	50.0%	40.7%	49.01	85.87	52.18
Other	36.26	59.37	46.70	21.4%	21.6%	21.4%	44.87	72.21	47.22
Total	$ 536.52	$ 936.51	$ 916.85				$ 723.48	$ 1,206.96	$ 765.08
Expected 2004 CMS Revenue PMPM							$ 1,255.15	$ 933.36	1,227.46
Expected Net Revenue PMPM							$ 531.67	$ (273.60)	$ 462.38

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Table 2B
San Diego County Long Term Care Integration
Summary of San Diego Experience - Nursing Home Residents (Adjusted for Part B Exposure) - Scenario B

	Projected 2000 Managed Care Costs			CMS Trends from 2000 to 2004			Trended 2004 Costs		
	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged and Disabled 65+ Dual	Disabled Dual	Composite Dual
2000									
Medicare Exposure Months	37,857	3,818	2,697				40,554	3,818	44,372
Inpatient Hospital PMPM	$ 173.13	$ 306.89	$ 281.05	26.5%	24.4%	26.5%	$ 228.06	$ 381.90	$ 241.30
Inpatient Hospital Days	1,736	3,551	2,816	0.0%	0.0%	0.0%	1,808	3,551	1,937
Inpatient Hospital $/Day	$ 1,197	$ 1,037	$ 1,198	26.5%	24.4%	26.5%	$ 1,514	$ 1,291	$ 1,494.60
Skilled Nursing Facility	$ 100.47	$ 111.66	$ 146.93	23.7%	22.1%	23.7%	$ 128.14	$ 136.33	$ 128.84
Developmentally Disabled ICF	-	-	-				-	-	-
Home Health Care	1.06	2.02	5.66	27.1%	11.7%	27.1%	1.74	2.26	1.78
Outpatient Facility	36.32	47.43	64.83	58.0%	68.3%	58.0%	60.40	79.81	62.07
Laboratory	11.48	53.40	42.27	21.4%	21.6%	21.4%	16.42	64.94	20.60
Physician	79.72	167.39	151.92	21.4%	21.6%	21.4%	102.62	203.58	111.30
Other Practitioner	12.25	30.34	29.18	21.4%	21.6%	21.4%	16.24	36.90	18.02
OP Mental Health Practitioner	0.01	0.06	0.04	21.4%	21.6%	21.4%	0.01	0.07	0.02
Ambulance	18.49	40.55	38.06	58.0%	68.3%	58.0%	31.28	68.23	34.46
DME	33.40	57.25	55.13	40.7%	50.0%	40.7%	49.01	85.87	52.18
Other	36.26	59.37	46.70	21.4%	21.6%	21.4%	44.87	72.21	47.22
Total	$ 502.59	$ 876.36	$ 861.77				$ 678.79	$ 1,132.10	$ 717.79
Expected 2004 CMS Revenue PMPM							$ 1,255.15	$ 933.36	1,227.46
Expected Net Revenue PMPM							$ 576.36	$ (198.74)	$ 509.67

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Table 3A
San Diego County Long Term Care Integration
Summary of San Diego Experience - Community Residents (Adjusted for Part B Exposure) - Scenario A

	Projected 2000 Managed Care Costs			CMS Trends from 2000 to 2004			Trended 2004 Costs		
	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged and Disabled 65+ Dual	Disabled Dual	Composite Dual
2000									
Medicare Exposure Months	300,439	157,580	95,059				395,498	157,580	553,078
Inpatient Hospital PMPM	$ 198.45	$ 369.60	$ 294.02	26.5%	24.4%	26.5%	$ 280.07	$ 459.94	$ 331.32
Inpatient Hospital Days	1,788	4,419	2,581	0.0%	0.0%	0.0%	1,979	4,419	2,535
Inpatient Hospital $/Day	$ 1,332	$ 1,004	$ 1,367	26.5%	24.4%	26.5%	$ 1,695	$ 1,249	$ 1,568.16
Skilled Nursing Facility	$ 44.92	$ 20.61	$ 46.74	23.7%	22.1%	23.7%	$ 56.12	$ 25.16	$ 47.30
Developmentally Disabled ICF	-	-	-				-	-	-
Home Health Care	23.08	19.06	35.95	27.1%	11.7%	27.1%	33.27	21.29	29.85
Outpatient Facility	21.87	36.01	31.45	58.0%	68.3%	58.0%	38.20	60.59	44.58
Laboratory	18.48	48.54	33.37	21.4%	21.6%	21.4%	26.78	59.03	35.97
Physician	89.44	161.56	123.44	21.4%	21.6%	21.4%	118.51	196.49	140.73
Other Practitioner	4.54	8.11	8.50	21.4%	21.6%	21.4%	6.67	9.86	7.58
OP Mental Health Practitioner	0.22	18.18	0.60	21.4%	21.6%	21.4%	0.38	22.11	6.57
Ambulance	6.78	10.18	10.09	58.0%	68.3%	58.0%	11.97	17.13	13.44
DME	17.51	28.16	28.72	40.7%	50.0%	40.7%	28.42	42.24	32.36
Other	43.40	54.02	35.39	21.4%	21.6%	21.4%	50.35	65.70	54.73
Total	$ 468.69	$ 774.03	$ 648.27				$ 650.74	$ 979.55	$ 744.42
Expected 2004 CMS Revenue PMPM							$ 877.87	$ 822.19	862.01
Expected Net Revenue PMPM							$ 227.13	$ (157.36)	$ 117.58

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Table 3B
San Diego County Long Term Care Integration
Summary of San Diego Experience - Community Residents (Adjusted for Part B Exposure) - Scenario B

	Projected 2000 Managed Care Costs			CMS Trends from 2000 to 2004			Trended 2004 Costs		
	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged and Disabled 65+ Dual	Disabled Dual	Composite Dual
2000									
Medicare Exposure Months	300,439	157,580	95,059				395,498	157,580	553,078
Inpatient Hospital PMPM	$ 165.93	$ 309.03	$ 245.84	26.5%	24.4%	26.5%	$ 234.17	$ 384.57	$ 277.02
Inpatient Hospital Days	1,375	3,399	1,985	0.0%	0.0%	0.0%	1,522	3,399	1,950
Inpatient Hospital $/Day	$ 1,448	$ 1,091	$ 1,486	26.5%	24.4%	26.5%	$ 1,843	$ 1,358	$ 1,704.91
Skilled Nursing Facility	$ 44.92	$ 20.61	$ 46.74	23.7%	22.1%	23.7%	$ 56.12	$ 25.16	$ 47.30
Developmentally Disabled ICF	-	-	-				-	-	-
Home Health Care	23.08	19.06	35.95	27.1%	11.7%	27.1%	33.27	21.29	29.85
Outpatient Facility	21.87	36.01	31.45	58.0%	68.3%	58.0%	38.20	60.59	44.58
Laboratory	18.48	48.54	33.37	21.4%	21.6%	21.4%	26.78	59.03	35.97
Physician	89.44	161.56	123.44	21.4%	21.6%	21.4%	118.51	196.49	140.73
Other Practitioner	4.54	8.11	8.50	21.4%	21.6%	21.4%	6.67	9.86	7.58
OP Mental Health Practitioner	0.22	18.18	0.60	21.4%	21.6%	21.4%	0.38	22.11	6.57
Ambulance	6.78	10.18	10.09	58.0%	68.3%	58.0%	11.97	17.13	13.44
DME	17.51	28.16	28.72	40.7%	50.0%	40.7%	28.42	42.24	32.36
Other	43.40	54.02	35.39	21.4%	21.6%	21.4%	50.35	65.70	54.73
Total	$ 436.17	$ 713.46	$ 600.09				$ 604.85	$ 904.18	$ 690.13
Expected 2004 CMS Revenue PMPM							$ 877.87	$ 822.19	862.01
Expected Net Revenue PMPM							$ 273.02	$ (81.99)	$ 171.88

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Table 4A
San Diego County Long Term Care Integration
Summary of San Diego Experience - Composite Population (Adjusted for Part B Exposure) - Scenario A

	Experience Summary - 2000			Management Savings Factors			Projected 2000 Managed Care Costs		
	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual
2000									
Medicare Exposure Months	338,296	161,398	97,756				338,296	161,398	97,756
Inpatient Hospital PMPM	$ 266.78	$ 494.36	$ 394.89	74.8%	74.8%	74.8%	$ 199.42	$ 369.54	$ 295.18
Inpatient Hospital Days	2,819	6,806	4,008	65.0%	65.0%	65.0%	1,832	4,424	2,605
Inpatient Hospital $/Day	$ 1,136	$ 872	$ 1,182	115.0%	115.0%	115.0%	$ 1,306	$ 1,002	$ 1,360
Skilled Nursing Facility	$ 60.16	$ 26.78	$ 58.24	85.0%	85.0%	85.0%	$ 51.14	$ 22.76	$ 49.50
Developmentally Disabled ICF	-	-	-	85.0%	85.0%	85.0%	-	-	-
Home Health Care	22.68	20.52	38.63	90.9%	90.9%	90.9%	20.61	18.65	35.12
Outpatient Facility	25.58	39.52	35.27	91.8%	91.8%	91.8%	23.48	36.28	32.37
Laboratory	19.28	53.00	36.61	91.8%	91.8%	91.8%	17.70	48.65	33.61
Physician	98.94	181.07	139.11	89.3%	89.3%	89.3%	88.35	161.70	124.22
Other Practitioner	6.05	9.67	10.16	89.3%	89.3%	89.3%	5.41	8.64	9.07
OP Mental Health Practitioner	0.22	19.87	0.65	89.3%	89.3%	89.3%	0.20	17.75	0.58
Ambulance	9.06	12.20	12.16	89.3%	89.3%	89.3%	8.09	10.89	10.86
DME	21.60	32.31	32.97	89.3%	89.3%	89.3%	19.28	28.85	29.44
Other	47.70	60.63	39.98	89.3%	89.3%	89.3%	42.60	54.14	35.71
Total	$ 578.05	$ 949.93	$ 798.68				$ 476.28	$ 777.85	$ 655.66
Reduction PMPM							$ 101.77	$ 172.08	$ 143.02
Reduction Expressed as Percentage of Unmanaged							17.6%	18.1%	17.9%

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Table 4B
San Diego County Long Term Care Integration
Summary of San Diego Experience - Composite Population (Adjusted for Part B Exposure) - Scenario B

	Experience Summary - 2000			Management Savings Factors			Projected 2000 Managed Care Costs		
	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual
2000									
Medicare Exposure Months	338,296	161,398	97,756				338,296	161,398	97,756
Inpatient Hospital PMPM	$ 266.78	$ 494.36	$ 394.89	62.5%	62.5%	62.5%	$ 166.74	$ 308.98	$ 246.81
Inpatient Hospital Days	2,819	6,806	4,008	50.0%	50.0%	50.0%	1,409	3,403	2,004
Inpatient Hospital $/Day	$ 1,136	$ 872	$ 1,182	125.0%	125.0%	125.0%	$ 1,420	$ 1,090	$ 1,478
Skilled Nursing Facility	$ 60.16	$ 26.78	$ 58.24	85.0%	85.0%	85.0%	$ 51.14	$ 22.76	$ 49.50
Developmentally Disabled ICF	-	-	-	85.0%	85.0%	85.0%	-	-	-
Home Health Care	22.68	20.52	38.63	90.9%	90.9%	90.9%	20.61	18.65	35.12
Outpatient Facility	25.58	39.52	35.27	91.8%	91.8%	91.8%	23.48	36.28	32.37
Laboratory	19.28	53.00	36.61	91.8%	91.8%	91.8%	17.70	48.65	33.61
Physician	98.94	181.07	139.11	89.3%	89.3%	89.3%	88.35	161.70	124.22
Other Practitioner	6.05	9.67	10.16	89.3%	89.3%	89.3%	5.41	8.64	9.07
OP Mental Health Practitioner	0.22	19.87	0.65	89.3%	89.3%	89.3%	0.20	17.75	0.58
Ambulance	9.06	12.20	12.16	89.3%	89.3%	89.3%	8.09	10.89	10.86
DME	21.60	32.31	32.97	89.3%	89.3%	89.3%	19.28	28.85	29.44
Other	47.70	60.63	39.98	89.3%	89.3%	89.3%	42.60	54.14	35.71
Total	$ 578.05	$ 949.93	$ 798.68				$ 443.60	$ 717.29	$ 607.29
Reduction PMPM							$ 134.45	$ 232.64	$ 191.39
Reduction Expressed as Percentage of Unmanaged							23.3%	24.5%	24.0%

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Table 5A
San Diego County Long Term Care Integration
Summary of San Diego Experience - Nursing Home Residents (Adjusted for Part B Exposure) - Scenario A

	Experience Summary - 2000			Management Savings Factors			Projected 2000 Managed Care Costs		
	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual
2000									
Medicare Exposure Months	37,857	3,818	2,697				37,857	3,818	2,697
Inpatient Hospital PMPM	$ 277.01	$ 491.02	$ 449.67	74.8%	74.8%	74.8%	$ 207.06	$ 367.04	$ 336.13
Inpatient Hospital Days	3,473	7,101	5,631	65.0%	65.0%	65.0%	2,257	4,616	3,660
Inpatient Hospital $/Day	$ 957	$ 830	$ 958	115.0%	115.0%	115.0%	$ 1,101	$ 954	$ 1,102
Skilled Nursing Facility	$ 118	$ 131	$ 173	85.0%	85.0%	85.0%	$ 100.47	$ 111.66	$ 146.93
Developmentally Disabled ICF	-	-	-	85.0%	85.0%	85.0%	-	-	-
Home Health Care	1.17	2.22	6.23	90.9%	90.9%	90.9%	1.06	2.02	5.66
Outpatient Facility	39.56	51.67	70.62	91.8%	91.8%	91.8%	36.32	47.43	64.83
Laboratory	12.50	58.17	46.05	91.8%	91.8%	91.8%	11.48	53.40	42.27
Physician	89.27	187.45	170.12	89.3%	89.3%	89.3%	79.72	167.39	151.92
Other Practitioner	13.72	33.98	32.68	89.3%	89.3%	89.3%	12.25	30.34	29.18
OP Mental Health Practitioner	0.01	0.07	0.05	89.3%	89.3%	89.3%	0.01	0.06	0.04
Ambulance	20.71	45.40	42.63	89.3%	89.3%	89.3%	18.49	40.55	38.06
DME	37.40	64.11	61.74	89.3%	89.3%	89.3%	33.40	57.25	55.13
Other	40.61	66.48	52.30	89.3%	89.3%	89.3%	36.26	59.37	46.70
Total	$ 650.16	$ 1,131.93	$ 1,104.94				$ 536.52	$ 936.51	$ 916.85
Reduction PMPM							$ 113.64	$ 195.42	$ 188.09
Reduction Expressed as Percentage of Unmanaged							17.5%	17.3%	17.0%

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Table 5B
San Diego County Long Term Care Integration
Summary of San Diego Experience - Nursing Home Residents (Adjusted for Part B Exposure) - Scenario B

	Experience Summary - 2000			Management Savings Factors			Projected 2000 Managed Care Costs		
	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual
2000									
Medicare Exposure Months	37,857	3,818	2,697				37,857	3,818	2,697
Inpatient Hospital PMPM	$ 277.01	$ 491.02	$ 449.67	62.5%	62.5%	62.5%	$ 173.13	$ 306.89	$ 281.05
Inpatient Hospital Days	3,473	7,101	5,631	50.0%	50.0%	50.0%	1,736	3,551	2,816
Inpatient Hospital $/Day	$ 957	$ 830	$ 958	125.0%	125.0%	125.0%	$ 1,197	$ 1,037	$ 1,198
Skilled Nursing Facility	$ 118	$ 131	$ 173	85.0%	85.0%	85.0%	$ 100.47	$ 111.66	$ 146.93
Developmentally Disabled ICF	-	-	-	85.0%	85.0%	85.0%	-	-	-
Home Health Care	1.17	2.22	6.23	90.9%	90.9%	90.9%	1.06	2.02	5.66
Outpatient Facility	39.56	51.67	70.62	91.8%	91.8%	91.8%	36.32	47.43	64.83
Laboratory	12.50	58.17	46.05	91.8%	91.8%	91.8%	11.48	53.40	42.27
Physician	89.27	187.45	170.12	89.3%	89.3%	89.3%	79.72	167.39	151.92
Other Practitioner	13.72	33.98	32.68	89.3%	89.3%	89.3%	12.25	30.34	29.18
OP Mental Health Practitioner	0.01	0.07	0.05	89.3%	89.3%	89.3%	0.01	0.06	0.04
Ambulance	20.71	45.40	42.63	89.3%	89.3%	89.3%	18.49	40.55	38.06
DME	37.40	64.11	61.74	89.3%	89.3%	89.3%	33.40	57.25	55.13
Other	40.61	66.48	52.30	89.3%	89.3%	89.3%	36.26	59.37	46.70
Total	$ 650.16	$ 1,131.93	$ 1,104.94				$ 502.59	$ 876.36	$ 861.77
Reduction PMPM							$ 147.57	$ 255.57	$ 243.17
Reduction Expressed as Percentage of Unmanaged							22.7%	22.6%	22.0%

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Table 6A
San Diego County Long Term Care Integration
Summary of San Diego Experience - Community Residents (Adjusted for Part B Exposure) - Scenario A

	Experience Summary - 2000			Management Savings Factors			Projected 2000 Managed Care Costs		
	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual
2000									
Medicare Exposure Months	300,439	157,580	95,059				300,439	157,580	95,059
Inpatient Hospital PMPM	$ 265.49	$ 494.44	$ 393.34	74.8%	74.8%	74.8%	$ 198.45	$ 369.60	$ 294.02
Inpatient Hospital Days	2,751	6,799	3,971	65.0%	65.0%	65.0%	1,788	4,419	2,581
Inpatient Hospital $/Day	$ 1,158.20	$ 872.70	$ 1,188.64	115.0%	115.0%	115.0%	$ 1,332	$ 1,004	$ 1,367
Skilled Nursing Facility	$ 52.85	$ 24.24	$ 54.99	85.0%	85.0%	85.0%	$ 44.92	$ 20.61	$ 46.74
Developmentally Disabled ICF	-	-	-	85.0%	85.0%	85.0%	-	-	-
Home Health Care	25.39	20.96	39.55	90.9%	90.9%	90.9%	23.08	19.06	35.95
Outpatient Facility	23.82	39.23	34.26	91.8%	91.8%	91.8%	21.87	36.01	31.45
Laboratory	20.13	52.87	36.35	91.8%	91.8%	91.8%	18.48	48.54	33.37
Physician	100.16	180.91	138.23	89.3%	89.3%	89.3%	89.44	161.56	123.44
Other Practitioner	5.09	9.08	9.52	89.3%	89.3%	89.3%	4.54	8.11	8.50
OP Mental Health Practitioner	0.25	20.35	0.67	89.3%	89.3%	89.3%	0.22	18.18	0.60
Ambulance	7.60	11.40	11.30	89.3%	89.3%	89.3%	6.78	10.18	10.09
DME	19.60	31.54	32.16	89.3%	89.3%	89.3%	17.51	28.16	28.72
Other	48.60	60.49	39.64	89.3%	89.3%	89.3%	43.40	54.02	35.39
Total	$ 568.97	$ 945.52	$ 789.99				$ 468.69	$ 774.03	$ 648.27
Reduction PMPM							$ 100.28	$ 171.49	$ 141.72
Reduction Expressed as Percentage of Unmanaged							17.6%	18.1%	17.9%

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Table 6B
San Diego County Long Term Care Integration
Summary of San Diego Experience - Community Residents (Adjusted for Part B Exposure) - Scenario B

	Experience Summary - 2000			Management Savings Factors			Projected 2000 Managed Care Costs		
	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual	Aged Dual	Disabled Dual	Disabled 65+ Dual
2000									
Medicare Exposure Months	300,439	157,580	95,059				300,439	157,580	95,059
Inpatient Hospital PMPM	$ 265.49	$ 494.44	$ 393.34	62.5%	62.5%	62.5%	$ 165.93	$ 309.03	$ 245.84
Inpatient Hospital Days	2,751	6,799	3,971	50.0%	50.0%	50.0%	1,375	3,399	1,985
Inpatient Hospital $/Day	$ 1,158.20	$ 872.70	$ 1,188.64	125.0%	125.0%	125.0%	$ 1,448	$ 1,091	$ 1,486
Skilled Nursing Facility	$ 52.85	$ 24.24	$ 54.99	85.0%	85.0%	85.0%	$ 44.92	$ 20.61	$ 46.74
Developmentally Disabled ICF	-	-	-	85.0%	85.0%	85.0%	-	-	-
Home Health Care	25.39	20.96	39.55	90.9%	90.9%	90.9%	23.08	19.06	35.95
Outpatient Facility	23.82	39.23	34.26	91.8%	91.8%	91.8%	21.87	36.01	31.45
Laboratory	20.13	52.87	36.35	91.8%	91.8%	91.8%	18.48	48.54	33.37
Physician	100.16	180.91	138.23	89.3%	89.3%	89.3%	89.44	161.56	123.44
Other Practitioner	5.09	9.08	9.52	89.3%	89.3%	89.3%	4.54	8.11	8.50
OP Mental Health Practitioner	0.25	20.35	0.67	89.3%	89.3%	89.3%	0.22	18.18	0.60
Ambulance	7.60	11.40	11.30	89.3%	89.3%	89.3%	6.78	10.18	10.09
DME	19.60	31.54	32.16	89.3%	89.3%	89.3%	17.51	28.16	28.72
Other	48.60	60.49	39.64	89.3%	89.3%	89.3%	43.40	54.02	35.39
Total	$ 568.97	$ 945.52	$ 789.99				$ 436.17	$ 713.46	$ 600.09
Reduction PMPM							$ 132.80	$ 232.06	$ 189.90
Reduction Expressed as Percentage of Unmanaged							23.3%	24.5%	24.0%

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Table 7
San Diego County Long Term Care Integration
Summary of San Diego Experience - Composite Population

	Experience Summary - 2000						Management Savings Factors						Projected 2000 Managed Care Costs					
	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled 65+ Dual	Disabled 65+ Single	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled 65+ Dual	Disabled 65+ Single	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled 65+ Dual	Disabled 65+ Dual
2000																		
Medicaid Exposure Months	338,296	57,140	161,398	297,009	97,756	15,459							338,296	57,140	161,398	297,009	97,756	15,459
Inpatient Hospital PMPM	$ 23.09	$ 46.32	$ 2.17	$ 114.63	$ 25.20	$ 93.16	92.2%	100.0%	92.2%	92.2%	92.2%	92.2%	$ 21.28	$ 46.32	$ 2.00	$ 105.69	$ 23.23	$ 85.89
Inpatient Hospital Days	488	827	34	1,758	532	1,514	87.9%	100.0%	87.9%	87.9%	87.9%	87.9%	429	827	30	1,545	468	1,331
Inpatient Hospital $/Day	$ 567	$ 672	$ 764	$ 782	$ 568	$ 738	104.9%	100.0%	104.9%	104.9%	104.9%	104.9%	$ 595	$ 672	$ 800	$ 821	$ 596	$ 774
Skilled Nursing Facility	310.68	61.14	91.75	71.55	107.78	93.31	100%	100%	100%	100%	100%	100%	310.68	61.14	91.75	71.55	107.78	93.31
Developmentally Disabled ICF	-	-	2.35	1.90	-	-	100%	100%	100%	100%	100%	100%	-	-	2.35	1.90	-	-
Home Health Care	3.97	1.12	10.65	11.86	5.16	3.47	100%	95.3%	100%	95.3%	100%	95.3%	3.97	1.06	10.65	11.31	5.16	3.31
Outpatient Facility	1.19	5.72	2.52	21.93	1.67	18.81	100%	95.8%	100%	95.8%	100%	95.8%	1.19	5.48	2.52	21.01	1.67	18.03
Laboratory	0.29	9.24	0.38	21.43	0.44	15.26	100%	95.8%	100%	95.8%	100%	95.8%	0.29	8.86	0.38	20.53	0.44	14.62
Physician	0.82	25.60	0.80	41.62	0.92	36.95	100%	94.5%	100%	94.5%	100%	94.5%	0.82	24.19	0.80	39.33	0.92	34.92
Other Practitioner	0.78	1.37	0.36	2.44	0.84	2.31	100%	94.5%	94.5%	94.5%	94.5%	94.5%	0.78	1.29	0.34	2.31	0.80	2.18
OP Mental Health Practitioner	-	-	-	0.01	-	-	100%	94.5%	94.5%	94.5%	94.5%	94.5%	-	-	-	0.01	-	-
Prescription Drugs	118.81	75.38	353.73	203.69	182.80	140.09	87%	87%	87%	87%	87%	87%	103.36	65.58	307.75	177.21	159.04	121.88
Ambulance	4.51	2.82	5.22	5.18	7.49	5.25	100%	94.5%	100%	94.5%	100%	94.5%	4.51	2.67	5.22	4.90	7.49	4.97
DME	8.45	7.71	10.55	14.63	10.70	13.92	100%	94.5%	100%	94.5%	100%	94.5%	8.45	7.29	10.55	13.83	10.70	13.15
IHSS	71.17	14.94	77.86	44.36	137.89	45.61	100%	100%	100%	100%	100%	100%	71.17	14.94	77.86	44.36	137.89	45.61
MSSP	2.28	0.08	-	-	5.64	-	100%	100%	100%	100%	100%	100%	2.28	0.08	-	-	5.64	-
Other	20.80	12.68	2.03	4.76	16.02	8.46	100%	94.5%	100%	94.5%	100%	94.5%	20.80	11.99	2.03	4.49	16.02	7.99
Total	$ 566.83	$ 264.12	$ 560.37	$ 560.01	$ 502.56	$ 476.60							$ 549.57	$ 250.89	$ 514.19	$ 518.44	$ 476.78	$ 445.86
Reduction PMPM													$ 17.25	$ 13.23	$ 46.18	$ 41.57	$ 25.77	$ 30.75

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Table 8
San Diego County Long Term Care Integration
Summary of San Diego Experience - Nursing Home Residents

	Experience Summary - 2000						Management Savings Factors						Projected 2000 Managed Care Costs					
	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled 65+ Dual	Disabled 65+ Single	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled Single	Disabled 65+ Dual	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled 65+ Dual	Disabled 65+ Single
2000																		
Medicaid Exposure Months	37,857	970	3,818	4,121	2,697	307							37,857	970	3,818	4,121	2,697	307
Inpatient Hospital PMPM	$ 18.04	$ 116.89	$ 9.58	$ 286.37	$ 97.69	$ 267.86	92.2%	100.0%	92.2%	92.2%	92.2%	92.2%	$ 16.63	$ 116.89	$ 8.83	$ 264.02	$ 90.06	$ 246.95
Inpatient Hospital Days	357	2,190	123	4,481	1,882	3,322	87.9%	100.0%	87.9%	87.9%	87.9%	87.9%	314	2,190	108	3,939	1,654	2,921
Inpatient Hospital $/Day	$ 606	$ 641	$ 938	$ 767	$ 623	$ 967	104.9%	100.0%	104.9%	104.9%	104.9%	104.9%	$ 636	$ 641	$ 981	$ 804	$ 653	$ 1,015
Skilled Nursing Facility	2,563.42	2,960.61	3,569.62	4,541.77	3,280.29	4,001.53	100%	100%	100%	100%	100%	100%	2,563.42	2,960.61	3,569.62	4,541.77	3,280.29	4,001.53
Developmentally Disabled ICF	-	-	-	-	-	-	100%	100%	100%	100%	100%	100%	-	-	-	-	-	-
Home Health Care	0.13	-	-	0.90	0.45	-	100%	95.3%	100%	95.3%	100%	95.3%	0.13	-	-	0.86	0.45	-
Outpatient Facility	0.08	9.92	1.21	24.77	0.28	3.55	100%	95.8%	100%	95.8%	100%	95.8%	0.08	9.50	1.21	23.73	0.28	3.40
Laboratory	0.07	11.69	0.56	42.68	0.22	34.79	100%	95.8%	100%	95.8%	100%	95.8%	0.07	11.20	0.56	40.90	0.22	33.34
Physician	0.69	25.28	1.93	85.25	1.18	68.93	100%	94.5%	100%	94.5%	100%	94.5%	0.69	23.89	1.93	80.56	1.18	65.14
Other Practitioner	0.14	0.78	0.42	4.21	0.10	2.14	100%	94.5%	94.5%	94.5%	94.5%	94.5%	0.14	0.74	0.40	3.98	0.09	2.02
OP Mental Health Practitioner	-	-	-	-	-	-	100%	94.5%	94.5%	94.5%	94.5%	94.5%	-	-	-	-	-	-
Prescription Drugs	177.14	213.25	414.00	444.88	309.94	407.73	87%	87%	87%	87%	87%	87%	154.11	185.52	360.18	387.05	269.64	354.72
Ambulance	5.75	15.40	18.69	32.48	14.39	20.19	100%	94.5%	100%	94.5%	100%	94.5%	5.75	14.55	18.69	30.69	14.39	19.08
DME	13.35	11.04	45.37	42.76	24.26	35.13	100%	94.5%	100%	94.5%	100%	94.5%	13.35	10.43	45.37	40.41	24.26	33.19
IHSS	2.63	-	3.43	6.80	16.66	4.28	100%	100%	100%	100%	100%	100%	2.63	-	3.43	6.80	16.66	4.28
MSSP	0.13	-	-	-	0.47	-	100%	100%	100%	100%	100%	100%	0.13	-	-	-	0.47	-
Other	12.72	3.24	10.65	20.34	9.19	-	100%	94.5%	100%	94.5%	100%	94.5%	12.72	3.07	10.65	19.22	9.19	-
Total	$ 2,794.28	$ 3,368.10	$ 4,075.46	$ 5,533.21	$ 3,755.11	$ 4,846.12							$ 2,769.85	$ 3,336.40	$ 4,020.87	$ 5,439.98	$ 3,707.18	$ 4,763.65

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Table 9
San Diego County Long Term Care Integration
Summary of San Diego Experience - Community Residents

	Experience Summary - 2000						Management Savings Factors						Projected 2000 Managed Care Costs					
	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled 65+ Dual	Disabled 65+ Single	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled 65+ Dual	Disabled 65+ Single	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled 65+ Dual	Disabled 65+ Single
2000																		
Medicaid Exposure Months	300,439	56,170	157,580	292,888	95,059	15,152							300,439	56,170	157,580	292,888	95,059	15,152
Inpatient Hospital PMPM	$ 23.72	$ 45.10	$ 1.99	$ 112.22	$ 23.14	$ 89.62	92.2%	100.0%	92.2%	92.2%	92.2%	92.2%	$ 21.87	$ 45.10	$ 1.84	$ 103.46	$ 21.34	$ 82.63
Inpatient Hospital Days	505	803	32	1,720	494	1,478	87.9%	100.0%	87.9%	87.9%	87.9%	87.9%	444	803	28	1,512	434	1,299
Inpatient Hospital $/Day	$ 562.52	$ 672.96	$ 760.12	$ 782.69	$ 566.41	$ 733.52	104.9%	100.0%	104.9%	104.9%	104.9%	104.9%	$ 591	$ 674	$ 789	$ 821	$ 590	$ 763
Skilled Nursing Facility	$ 26.82	$ 11.06	$ 7.49	$ 8.66	$ 17.77	$ 14.13	100%	100%	100%	100%	100%	100%	$ 26.82	$ 11.06	$ 7.49	$ 8.66	$ 17.77	$ 14.13
Developmentally Disabled ICF	-	-	2.40	1.93	-	-	100%	100%	100%	100%	100%	100%	-	-	2.40	1.93	-	-
Home Health Care	4.46	1.14	10.91	12.01	5.29	3.55	100%	95.3%	100%	95.3%	100%	95.3%	4.46	1.08	10.91	11.46	5.29	3.38
Outpatient Facility	1.33	5.64	2.55	21.89	1.71	19.12	100%	95.8%	100%	95.8%	100%	95.8%	1.33	5.41	2.55	20.97	1.71	18.32
Laboratory	0.31	9.20	0.37	21.13	0.44	14.87	100%	95.8%	100%	95.8%	100%	95.8%	0.31	8.82	0.37	20.25	0.44	14.24
Physician	0.84	25.60	0.77	41.01	0.92	36.30	100%	94.5%	100%	94.5%	100%	94.5%	0.84	24.19	0.77	38.75	0.92	34.30
Other Practitioner	0.86	1.38	0.36	2.42	0.86	2.31	100%	94.5%	94.5%	94.5%	94.5%	94.5%	0.86	1.30	0.34	2.29	0.82	2.18
OP Mental Health Practitioner	-	-	-	0.01	-	-	100%	94.5%	94.5%	94.5%	94.5%	94.5%	-	-	-	0.01	-	-
Prescription Drugs	111.46	73.00	352.27	200.30	179.19	134.67	87%	87%	87%	87%	87%	87%						
Ambulance	4.35	2.60	4.89	4.80	7.29	4.95	100%	94.5%	100%	94.5%	100%	94.5%	4.35	2.46	4.89	4.54	7.29	4.68
DME	7.83	7.66	9.70	14.24	10.32	13.49	100%	94.5%	100%	94.5%	100%	94.5%	7.83	7.24	9.70	13.45	10.32	12.75
Other	21.82	12.85	1.82	4.54	16.21	8.63	100%	94.5%	100%	94.5%	100%	94.5%	21.82	12.14	1.82	4.29	16.21	8.15
Total	$ 286.16	$ 210.52	$ 475.20	$ 490.04	$ 410.28	$ 388.07							$ 172.85	$ 134.09	$ 122.75	$ 274.95	$ 229.24	$ 241.20
Reduction PMPM													$ 113.31	$ 76.43	$ 352.45	$ 215.09	$ 181.04	$ 146.87
Reduction Expressed as Percentage of Unmanaged													39.6%	36.3%	74.2%	43.9%	44.1%	37.8%

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Table 10
San Diego County Long Term Care Integration
Summary of San Diego Experience - IHSS

	Experience Summary - 2000						Management Savings Factors						Projected 2000 Managed Care Costs					
	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled 65+ Dual	Disabled 65+ Single	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled 65+ Dual	Disabled 65+ Single	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled 65+ Dual	Disabled 65+ Single
2000																		
Medicaid Exposure Months	56,102	2,073	24,432	30,453	31,551	1,933							56,102	2,073	24,432	30,453	31,551	1,933
Inpatient Hospital PMPM	$ 49.64	$ 121.34	$ 2.10	$ 200.85	$ 40.79	$ 149.00	92.2%	100.0%	92.2%	92.2%	92.2%	92.2%	$ 45.77	$ 121.34	$ 1.94	$ 185.18	$ 37.60	$ 137.37
Inpatient Hospital Days	1,045	2,032	42	3,337	845	2,763	87.9%	100.0%	87.9%	87.9%	87.9%	87.9%	919	2,032	37	2,933	743	2,428
Inpatient Hospital $/Day	$ 570	$ 717	$ 605	$ 722	$ 579	$ 647	104.9%	100.0%	104.9%	104.9%	104.9%	104.9%	$ 598	$ 717	$ 629	$ 758	$ 607	$ 679
Skilled Nursing Facility	17.19	7.84	4.64	11.36	13.21	19.07	100%	100%	100%	100%	100%	100%	17.19	7.84	4.64	11.36	13.21	19.07
Developmentally Disabled ICF	-	-	-	-	-	-	100%	100%	100%	100%	100%	100%	-	-	-	-	-	-
Home Health Care	15.50	10.41	54.84	70.47	14.91	10.75	100%	95.3%	100%	95.3%	100%	95.3%	15.50	9.92	54.84	67.19	14.91	10.25
Outpatient Facility	1.25	5.03	3.31	48.38	1.28	46.01	100%	95.8%	100%	95.8%	100%	95.8%	1.25	4.82	3.31	46.35	1.28	44.09
Laboratory	0.23	27.68	0.34	35.82	0.36	21.95	100%	95.8%	100%	95.8%	100%	95.8%	0.23	26.52	0.34	34.32	0.36	21.03
Physician	0.46	69.99	0.47	65.18	0.80	53.02	100%	94.5%	100%	94.5%	100%	94.5%	0.46	66.14	0.47	61.59	0.80	50.10
Other Practitioner	1.63	5.28	0.65	4.52	1.09	3.27	100%	94.5%	94.5%	94.5%	94.5%	94.5%	1.63	4.99	0.61	4.27	1.03	3.09
OP Mental Health Practitioner	-	-	-	0.01	-	-	100%	94.5%	94.5%	94.5%	94.5%	94.5%	-	-	-	0.01	-	-
Prescription Drugs	176.89	147.87	524.73	355.14	238.76	234.27	87%	87%	87%	87%	87%	87%	153.90	128.64	456.52	308.97	207.72	203.82
Ambulance	11.86	8.57	15.64	13.00	14.23	12.32	100%	94.5%	100%	94.5%	100%	94.5%	11.86	8.10	15.64	12.28	14.23	11.64
DME	18.14	29.33	37.80	60.78	18.58	36.33	100%	94.5%	100%	94.5%	100%	94.5%	18.14	27.72	37.80	57.44	18.58	34.33
IHSS	429.15	411.89	514.33	432.68	427.23	364.73	100%	100%	100%	100%	100%	100%	429.15	411.89	514.33	432.68	427.23	364.73
MSSP	12.76	2.26	-	-	16.34	-	100%	100%	100%	100%	100%	100%	12.76	2.26	-	-	16.34	-
Other	36.51	101.84	6.84	15.70	22.79	4.15	100%	94.5%	100%	94.5%	100%	94.5%	36.51	96.24	6.84	14.84	22.79	3.93
Total	$ 771.21	$ 949.34	$ 1,165.69	$ 1,313.87	$ 810.37	$ 954.89							$ 744.35	$ 916.42	$ 1,097.28	$ 1,236.48	$ 776.08	$ 903.45
Reduction PMPM													$ 26.86	$ 32.92	$ 68.42	$ 77.40	$ 34.29	$ 51.44

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Table 11
San Diego County Long Term Care Integration
Summary of San Diego Experience - MSSP

	Experience Summary - 2000						Management Savings Factors						Projected 2002 Managed Care Costs					
	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled 65+ Dual	Disabled 65+ Single	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled 65+ Dual	Disabled 65+ Single	Aged Dual	Aged Single	Disabled Dual	Disabled Single	Disabled 65+ Dual	Disabled 65+ Single
2000																		
Medicaid Exposure Months	3,118	23			2,232								3,118	23	-	-	2,232	-
Inpatient Hospital PMPM	$ 69.76	$ -			$ 26.29		92.2%	100.0%	92.2%	92.2%	92.2%	92.2%	$ 64.31	$ -	$ -	$ -	$ 24.24	$ -
Inpatient Hospital Days	1,474	-			522		87.9%	100.0%	87.9%	87.9%	87.9%	87.9%	1,296	-	-	-	458	-
Inpatient Hospital $/Day	$ 568	$ -			$ 605		104.9%	100.0%	104.9%	104.9%	104.9%	104.9%	$ 595				$ 635	
Skilled Nursing Facility	27.01	-			12.04		100%	100%	100%	100%	100%	100%	27.01	-	-	-	12.04	-
Developmentally Disabled ICF	-	-			-		100%	100%	100%	100%	100%	100%	-	-	-	-	-	-
Home Health Care	232.14	204.00			224.95		100%	95.3%	100%	95.3%	100%	95.3%	232.14	194.50	-	-	224.95	-
Outpatient Facility	0.41	-			0.16		100%	95.8%	100%	95.8%	100%	95.8%	0.41	-	-	-	0.16	-
Laboratory	0.08	-			0.06		100%	95.8%	100%	95.8%	100%	95.8%	0.08	-	-	-	0.06	-
Physician	0.18	-			0.16		100%	94.5%	100%	94.5%	100%	94.5%	0.18	-	-	-	0.16	-
Other Practitioner	1.84	-			1.63		100%	94.5%	94.5%	94.5%	94.5%	94.5%	1.84	-	-	-	1.54	-
OP Mental Health Practitioner	-	-			-		100%	94.5%	94.5%	94.5%	94.5%	94.5%	-	-	-	-	-	-
Prescription Drugs	245.01	85.13			285.22		87%	87%	87%	87%	87%	87%	213.16	74.06	-	-	248.14	-
Ambulance	26.61	-			25.86		100%	94.5%	100%	94.5%	100%	94.5%	26.61	-	-	-	25.86	-
DME	21.38	-			22.40		100%	94.5%	100%	94.5%	100%	94.5%	21.38	-	-	-	22.40	-
IHSS	585.97	280.38			576.36		100%	100%	100%	100%	100%	100%	585.97	280.38	-	-	576.36	-
MSSP	246.95	204.00			247.03		100%	100%	100%	100%	100%	100%	246.95	204.00	-	-	247.03	-
Other	53.64	-			27.93		100%	94.5%	100%	94.5%	100%	94.5%	53.64	-	-	-	27.93	-
Total	$ 1,510.99	$ 773.50			$ 1,450.08								$ 1,473.69	$ 752.94	$ -	$ -	$ 1,410.87	$ -
Reduction PMPM													$ 37.29	$ 20.57	$ -	$ -	$ 39.22	$ -

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